Suicide ideation among nursing home residents in the US: conceptual issues and the international context.

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Dr Briony Jain

Suicidal ideation and behaviour among nursing home and long-term care (LTC) residents is of growing concern internationally. The study by Temkin-Greener and colleagues represents the first study of suicidal ideation in US nursing homes using existing national-level assessment data from the Minimum Data Set (MDS 3.0), and is also one of the few studies to examine the relationship between organisational level factors and suicidal ideation and behaviour among LTC residents in the US since the early 1990's (1, 2). Thus, it adds an important contribution to the expanding international knowledge base on suicidal behaviours among nursing home and LTC residents (3, 4).

As both the conversation that this paper contributes to and the readership of the American Journal of Geriatric Psychiatry extend far beyond US borders, it is useful to consider the findings from this latest US study in the broader international context. For example, a recent national population-based study on completed suicide among nursing home residents in Australia found that 50% of residents who died by suicide had resided in the nursing home for less than 12 months (5). This supports the key finding of the current study by Temkin-Greener and colleagues that suicidal ideation (and thus suicide risk) is highest at admission and declines with duration of nursing home stay.

In addition to identifying the two-week prevalence of suicidal ideation among LTC residents, the study by Temkin-Greener et al, also identifies several potentially modifiable individual and facility-level factors associated with suicidal ideation risk including: depression, aggressive behaviour, psychiatric conditions, pain, and the use of medications such as antidepressants, antianxiety,

antipsychotics, and hypnotics. A particularly interesting finding was that the odds for suicidal ideation were lower for residents with dementia and those with moderate/severe cognitive impairment. In other words, dementia may be somewhat of a protective factor for suicide. This was also identified in a recent data linkage study from Australia on health and care related risk factors for suicide among nursing home residents (6) and warrants further discussion and investigation.

Finally, the authors concluded that the PHQ-9 item used to assess suicidal ideation may not be well understood and the frequency of suicidal ideation in nursing homes may be under-reported. I commend the use of existing routinely-collected data to attempt to investigate and measure suicidal ideation and behaviour in LTC. However, as the authors point out, there are limitations with the accuracy of the MDS 3.0 data for this purpose. Namely, the data used to measure suicidal ideation for this research comes from a single question in the Patient Health Questionnaire (PHQ-9) which asks residents "over the last 2 weeks, have you been bothered by thoughts that you would be better off dead, or hurting yourself in some way." This is essentially asking about two different and distinct concepts at once: thoughts that one would be better off dead (which is more closely aligned with the concept of death wishes or death ideation); and thoughts of hurting oneself (self-harm or suicidal ideation). While the literature shows a positive association between PHQ-9 item and the risk of suicide death in other populations (7, 8), this is the first study to date that uses this item on PHQ-9 to measure suicidal ideation among nursing home residents. The validity of which remains to be determined, as many older people including nursing home and LTC residents often wish for death in the sense that they hope it comes soon but may never take any action to make it happen themselves. In this way, death wishes/death ideation is a distinct concept from suicidal ideation occurring somewhere else along the spectrum of suicidal behaviour. As the PHQ-9 item contains two separate constructs that cannot be separated out later during analysis, it is impossible to determine which of the two (or the impact of both combined) is the true risk predictor of future suicidal behaviour. Further, it has also been demonstrated that many deaths due to suicide among Veteran Health Administration patients were not predicted by this item at all (71.6%) (8). The authors

highlight this issue in the discussion about the difficulties of having multiple constructs in a single question and suggest that further research should explore how this item is understood by residents and staff when completing the questionnaire. While this is a start, the problem is also part of a broader conceptual issue about how we understand and therefore respond to suicidal and end-of-life behaviour among older adults particularly those living in LTC. This also requires research attention and resolution.

Various changes have been made over the years to improve the quality of data collected through versions of the MDS to provide an accurate reading of the LTC resident population and their care needs. The most recent being the implementation of the Minimum Data Set (MDS) 3.0 in 2010, which now requires all US NHs (certified by Medicare and Medicaid) to routinely administer the Patient Health Questionnaire (PHQ-9) to all residents. Ten years on and this latest work by Temkin-Greener and colleagues highlights an important opportunity to improve it further.

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